Iron (Venofer)

Provider Order Form rev. 12/01/2021

AleraCare
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PATIENT INFORMATION

Patient Name: DOB:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

ICD-10 CODE

Iron deficiency anemia for

☐ Z99.2 Hemodialysis Dependent Chronic Kidney Disease (HDD-CKD)

☐ N18.6 Non-Dialysis Dependent Chronic Kidney Disease (NDD-CKD)

☐ Z99.2 Peritoneal Dialysis Dependent-Chronic Kidney Disease (PDD-CKD)

☐ Other: _____

MEDICATION ORDER

Iron sucrose (Venofer) intravenous infusion

Dose:

- ☐ 100mg in 100ml 0.9% sodium chloride over 30 minutes
- ☐200mg in 100ml 0.9% sodium chloride over 30 minutes
- ☐300mg in 250ml 0.9% sodium chloride over 1.5 hours
- ☐ 400mg in 250ml 0.9% sodium chloride over 2.5 hours
- ☐ _____
- Frequency:
  ☐Once ☐ Every 2-3 days x _____ doses
  ☐Daily x _____ doses ☐ Weekly x _____ doses
  ☐Monthly x _____ doses ☐ Other: _____

SPECIAL INSTRUCTIONS

☐ Flush with 0.9% sodium chloride at the completion of infusion
☐ Patient required to stay for 30-min observation period

Provider Name (Print) **Provider Signature** **Date**

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication ☐ History and Physical Report
☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ ANA (SLE) ☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months